Complete Summary

GUIDELINE TITLE

Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: recommendation statement. Ann Intern Med 2004 Apr 6;140(7):554-6. PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This updates a previously published guideline: U.S. Preventive Services Task Force. Screening for problem drinking. In: Guide to clinical preventive services, 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. p. 567-82.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Alcohol misuse

Note: This guideline does not address alcohol dependence.

GUIDELINE CATEGORY

Counseling
Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

- To summarize the U.S. Preventive Services Task Force (USPSTF) recommendations on behavioral counseling interventions to reduce alcohol misuse in primary care patients and the supporting evidence
- To update the 1996 recommendations contained in the Guide to Clinical Preventive Services, second edition

TARGET POPULATION

- Adolescents and adults, including pregnant patients, seen in primary care settings
- Persons drinking more than 7 drinks per week or more than 3 drinks per occasion for women, and more than 14 drinks per week or more than 4 drinks per occasion for men
- Persons who are currently experiencing physical, social, or psychological harm from alcohol use but do not meet criteria for dependence.

INTERVENTIONS AND PRACTICES CONSIDERED

Screening

1. Screening for alcohol misuse using validated screening instruments, including:
    - For the general population:
        - AUDIT (the Alcohol Use Disorders Identification Test)
        - CAGE (feeling the need to Cut down, Annoyed by criticism, Guilty about drinking, and need for an Eye-opener in the morning)
    - For pregnant women:
        - TWEAK ("T" stands for tolerance, "W" stands for close friends/relatives worrying or complaining about your drinking,

"E" for eye-openers, "A" for amnesia (blackouts), and "K" for feeling the need to cut down on drinking)
        - T-ACE questionnaire
    - For adolescents:
        - CRAFFT questionnaire (Note: screening for adolescents is discussed but not recommended)

Counseling

1. Counseling sessions
    - Initial
    - Multi-contact
2. 5As behavioral counseling framework:
    - Assess alcohol consumption with a brief screening tool followed by clinical assessment as needed.
    - Advise patients to reduce alcohol consumption to moderate levels.
    - Agree on individual goals for reducing alcohol use or abstinence (if indicated).
    - Assist patients with acquiring the motivations, self-help skills, or supports needed for behavior change.
    - Arrange follow-up support and repeated counseling, including referring dependent drinkers for specialty treatment.
3. Brief provider training or access to specially trained primary care practitioners or health educators
4. Office-level systems supports (prompts, reminders, counseling algorithms, and patient education materials)
5. Patient education

MAJOR OUTCOMES CONSIDERED

Key Question No. 1: Is there direct evidence that behavioral counseling interventions to reduce risky or harmful alcohol use reduce morbidity and/or mortality?

Key Question No. 2: What methods were used to identify target populations for the behavioral counseling interventions?

Key Question No. 3: What are adverse effects associated with alcohol use screening and screening-related assessment?

Key Question No. 4: Does behavioral counseling intervention in primary care reduce risky or harmful alcohol use in the targeted subgroup?

Key Question No. 4a: What are the essential elements of efficacious interventions?

Key Question No. 5: Are there other positive outcomes from behavior counseling interventions to reduce risky/harmful alcohol use?

Key Question No. 6: What are adverse effects associated with behavioral counseling interventions for risky/harmful alcohol use?

Key Question No. 7: What healthcare system influences are present in effective screening and screening-related assessments and interventions to reduce risky/harmful alcohol use and/or its outcomes?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Health Sciences University Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Search Strategy

Using methods of the USPSTF, EPC staff developed an analytic framework and 7 key questions to guide the literature review.

Key questions 1, 4, 5, and 7: EPC staff searched the Cochrane Database of Systematic Reviews and Database of Research Effectiveness (DARE) (2001, issues 2 and 3; 2002 issue 1) using an inclusive search strategy (alcohol* or drink*) to identify recent high-quality systematic reviews addressing brief interventions to reduce risky/harmful alcohol use in primary care. They found five well-conducted recent systematic reviews of interventions and reviewed their bibliographies to ascertain any studies not identified through separate searches of other primary databases (described below). Unpublished studies were located through expert contacts and referrals. EPC staff also retrieved relevant literature reviewed in the 1996 Guide to Clinical Preventive Services. They searched MEDLINE, Cochrane Controlled Clinical Trials, PsychInfo, HealthSTAR, and CINAHL databases from 1994 through April 2002, using search strings detailed in Table 6 of the Appendix (see Companion document). One investigator reviewed 4,331 non-duplicative titles and abstracts, and a second investigator reviewed a random 35% of titles/abstracts for concordance. Approximately 95% agreement was found, and no articles that met review inclusion criteria were discrepantly coded by the two reviewers. For included studies, no matter the source, one primary reviewer abstracted relevant information using data-abstraction forms. All key data that appeared in the evidence tables were checked by a second reviewer. Quality of the articles was graded using the USPSTF criteria, supplemented by guidelines on evaluating study randomization, attrition, and intention-to-treat analyses from the Cochrane Drug and Alcohol Group.

Key questions 3 and 6: EPC staff conducted searches in MEDLINE and PsychInfo from 1994 through April 2002 combining the terms described in Table 6 of the

Appendix (see Companion Document), with "adverse effects of screening" and "adverse effects of counseling" to identify any literature on the harms of alcohol screening, screening-related assessment, or intervention, but none was found.

Inclusion and Exclusion Criteria

To be eligible, studies had to be conducted in a primary care setting, as defined in a recent Institute of Medicine report. Other clinical settings, such as emergency departments and hospitals, were excluded from this review to maximize the applicability of the review findings to primary care. Titles and abstracts were reviewed for eligibility, and full-text articles of potentially eligible studies were re-assessed using the same criteria. Included articles were re-reviewed by a second investigator to confirm eligibility and quality ratings. Studies receiving a rating of "poor-quality" according to the USPSTF criteria were excluded from the review.

NUMBER OF SOURCE DOCUMENTS

4,331 abstract/titles were captured in database searches. Of these 44 were included in the literature review, and of these 44, 16 articles were included in the summary of evidence.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force grades the **quality of the overall evidence** for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Health Sciences University Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Data Extraction, Reliability and Validity Assessments

All studies were abstracted by one of the study investigators into standardized data-abstraction forms developed for this review. Data-abstraction forms addressed three issues: 1) study recruitment, randomization, and attrition (adapted from CONSORT104), 2) study design, conduct, and results, and 3) quality. A separate audit of study outcomes was conducted by one of 2 research assistants, and all items abstracted into final evidence tables were double-checked by a second reviewer. A second investigator also conducted a quality review audit of each study, emphasizing the key aspects of quality in this literature (allocation concealment, attrition and replacement of missing values, baseline and final comparability of groups, adequate intervention delivery, and masking of patients and outcome assessment). The final quality rating for each study (Good, Fair, Poor) reported in the evidence tables was based on the USPSTF criteria and assigned by consensus of the investigator team.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus,

outcomes tables allow the USPSTF to examine directly how the preventive services affect benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The Task Force grades its **recommendations** according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

COST ANALYSIS

The U.S. Preventive Services Task Force (USPSTF) found only 2 poor-to-fair quality studies evaluating the cost-effectiveness of alcohol behavioral counseling interventions. Interpreting their findings is complicated due to poor comparability of definitions and lack of inclusion of consistent outcomes. Despite these limitations, the studies tend to show that brief interventions could provide cost savings due to reductions in emergency department visits and hospitalizations.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and

documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole USPSTF before final recommendations are confirmed.

Recommendation of Others. Recommendations on behavioral counseling interventions to reduce alcohol misuse from the following groups were discussed: the American Medical Association; the American Society of Addiction Medicine; the Canadian Task Force on Preventive Health Care; the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse (see Clinical Considerations below) by adults, including pregnant women, in primary care settings. **B recommendation.**

The USPSTF found good evidence that screening in primary care settings can accurately identify patients whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence, but place them at risk for increased morbidity and mortality, and good evidence that brief behavioral counseling interventions with follow-up produce small to moderate reductions in alcohol consumption that are sustained over 6- to 12-month periods or longer. The USPSTF found some evidence that interventions lead to positive health outcomes 4 or more years post-intervention, but found limited evidence that screening and behavioral counseling reduce alcohol-related morbidity. The evidence on the effectiveness of counseling to reduce alcohol consumption during pregnancy is limited; however, studies in the general adult population show that behavioral counseling interventions are effective among women of childbearing age. The USPSTF concluded that the benefits of behavioral counseling interventions to reduce alcohol misuse by adults outweigh any potential harms.

The USPSTF concludes that the evidence is insufficient to recommend for or against screening and behavioral counseling interventions to prevent or reduce alcohol misuse by adolescents in primary care settings. **I recommendation.**

The USPSTF found limited evidence evaluating the effectiveness of screening and behavioral counseling interventions in primary care settings to prevent or reduce alcohol misuse by adolescents. The USPSTF concluded that the evidence is insufficient to assess the potential benefits and harms of screening and behavioral counseling interventions in this population.

Clinical Considerations

- Alcohol misuse includes "risky/hazardous" and "harmful" drinking that places individuals at risk for future problems. "Risky" or "hazardous" drinking has been defined in the United States as more than 7 drinks per week or more than 3 drinks per occasion for women, and more than 14 drinks per week or more than 4 drinks per occasion for men. "Harmful drinking" describes persons who are currently experiencing physical, social, or psychological harm from alcohol use but do not meet criteria for dependence. Alcohol abuse and dependence are associated with repeated negative physical, psychological, and social effects from alcohol. The USPSTF did not evaluate the effectiveness of interventions for alcohol dependence because the benefits of these interventions are well established and referral or specialty treatment is recommended for those meeting the diagnostic criteria for dependence.
- Light to moderate alcohol consumption in middle-aged or older adults has been associated with some health benefits, such as reduced risk for coronary heart disease. Moderate drinking has been defined as 2 standard drinks (e.g., 12 ounces of beer) or less per day for men and 1 drink or less per day for women and persons older than 65, but recent data suggest comparable benefits from as little as 1 drink 3 to 4 times a week.
- The Alcohol Use Disorders Identification Test (AUDIT) is the most studied screening tool for detecting alcohol-related problems in primary care settings. It is sensitive for detecting alcohol misuse and abuse or dependence and can be used alone or embedded in broader health risk or lifestyle assessments. The 4-item CAGE (feeling the need to Cut down, Annoyed by criticism, Guilty about drinking, and need for an Eye-opener in the morning) is the most popular screening test for detecting alcohol abuse or dependence in primary care. The TWEAK, a 5-item scale, and the T-ACE are designed to screen pregnant women for alcohol misuse. They detect lower levels of alcohol consumption that may pose risks during pregnancy. Clinicians can choose screening strategies that are appropriate for their clinical population and setting. Screening tools are available at the National Institute on Alcohol Abuse and Alcoholism Web site: http://www.niaaa.nih.gov/publications/instable.htm.
- Effective interventions to reduce alcohol misuse include an initial counseling session of about 15 minutes, feedback, advice, and goal-setting. Most also include further assistance and follow-up. Multi-contact interventions for patients ranging widely in age (12-75 years) are shown to reduce mean alcohol consumption by 3 to 9 drinks per week, with effects lasting up to 6 to 12 months after the intervention. They can be delivered wholly or in part in the primary care setting, and by 1 or more members of the health care team, including physician and non-physician practitioners. Resources that help clinicians deliver effective interventions include brief provider training or access to specially trained primary care practitioners or health educators, and the presence of office-level systems supports (prompts, reminders, counseling algorithms, and patient education materials).
- Primary care screening and behavioral counseling interventions for alcohol misuse can be described with reference to the 5-As behavioral counseling framework: assess alcohol consumption with a brief screening tool followed by clinical assessment as needed; advise patients to reduce alcohol consumption to moderate levels; agree on individual goals for reducing alcohol use or abstinence (if indicated); assist patients with acquiring the motivations, self-help skills, or supports needed for behavior change; and

arrange follow-up support and repeated counseling, including referring dependent drinkers for specialty treatment. Common practices that complement this framework include motivational interviewing, the 5 Rs used to treat tobacco use, and assessing readiness to change.

- The optimal interval for screening and intervention is unknown. Patients with past alcohol problems, young adults, and other high-risk groups (e.g., smokers) may benefit most from frequent screening.
- All pregnant women and women contemplating pregnancy should be informed of the harmful effects of alcohol on the fetus. Safe levels of alcohol consumption during pregnancy are not known; therefore, pregnant women are advised to abstain from drinking alcohol. More research into the efficacy of primary care screening and behavioral intervention for alcohol misuse among pregnant women is needed.
- The benefits of behavioral intervention for preventing or reducing alcohol misuse in adolescents are not known. The CRAFFT questionnaire was recently validated for screening adolescents for substance abuse in the primary care setting. The benefits of screening this population will need to be evaluated as more effective interventions become available in the primary care setting.

Definitions

Strength of Recommendations

The Task Force grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

Strength of Evidence

The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Effectiveness of Screening Instruments

A recent, good-quality systematic review of 38 studies of screening for alcohol misuse by adults in primary care settings (age range 35-47 years) supports the effectiveness of available screening instruments. The AUDIT incorporates questions about consequences of drinking along with questions about drinking quantity and frequency; its sensitivity ranges from 51 to 97% and its specificity ranges from 78 to 96%. The sensitivity of the CAGE ranges from 43 to 94%, and its specificity ranges from 70 to 97%. TWEAK, which is designed to screen pregnant women for alcohol misuse, has a reported sensitivity ranging from 59 to 87% and a specificity ranging from 72 to 94%. The CRAFFT questionnaire, designed to screen adolescents, has a reported sensitivity of 92% and a specificity of 64%. Preliminary data indicate that other screening tests, such as the CAGE-AA and the Simple Screening Instrument for Alcohol and Other Drug Abuse (SSI-AOD), are reliable in identifying alcohol and other drug abuse and dependence among adolescents in the primary care setting; however, the sensitivity and specificity of these tests have not yet been assessed. If screened for alcohol misuse using essentially any validated instrument, approximately 8 to 18% of general primary care patients would screen positive, with about 50% remaining eligible for brief intervention after completing further assessment. A recent meta-analysis concluded that 3 to 18% of patients would screen positive for alcohol misuse, with 1 to 5% given brief interventions after completing assessment. Biological markers, such as carbohydrate deficient transferrin (CDT) and serum gamma-glutamyltransferase (GGT), are poor indicators of alcohol misuse.

Effectiveness of Counseling Interventions

Long-term Health Outcomes

The U.S. Preventive Services Task Force (USPSTF) review found that counseling interventions had mixed results on the long-term health outcomes of adults. No studies found statistically significant, long-term effects on morbidity. The combined results from these studies suggest mean reductions in alcohol consumption ranging from 3 to 9 drinks per week (13-34% net reduction in drinking) in the intervention group compared with the control group after 6 to 12 months of follow-up. The majority of good-quality studies of primary care interventions for people with risky or harmful drinking found that 10 to 19% more intervention participants no longer reported drinking at levels that were harmful or risky compared with controls. A meta-analysis found that the pooled absolute risk reduction ranged from 7 to 14% among those considered eligible to receive brief intervention and reported a number needed to screen of 385. All effective interventions included at least feedback, advice, and goal-setting, while most also delivered further assistance and follow-up. These elements are consistent with the 5 As approach to describing behavioral counseling interventions in clinical care adopted by the USPSTF.

Interventions for Pregnant Women

The USPSTF identified 3 fair-to-good quality studies evaluating multi-contact interventions for pregnant women in primary care settings (age ranges early 20s to 30 years). These studies tended to include lighter drinkers, to be smaller, and to have shorter follow-up periods than studies of other populations because the aim of the interventions was to have patients reduce or stop drinking during pregnancy. Although the results were not statistically significant, 1 of the studies

found a trend toward lower alcohol consumption and greater abstinence during pregnancy in the intervention group than in the control group. Although other studies targeted toward pregnant women found small or negligible effects of behavioral counseling interventions in reducing alcohol consumption, the USPSTF review did not find any difference in the effectiveness of interventions between men and non-pregnant women.

Subgroups Most Likely to Benefit from Frequent Screening

The optimal interval for screening and intervention is unknown. Patients with past alcohol problems, young adults, and other high-risk groups (e.g., smokers) may benefit most from frequent screening.

POTENTIAL HARMS

The U.S. Preventive Services Task Force (USPSTF) found little direct evidence regarding harms of screening or behavioral counseling interventions for alcohol misuse. In a few studies, higher attrition rates in intervention compared with control groups suggest that alcohol misuse interventions may be objectionable for some individuals. Two potential harms of these interventions among adults include a possible reduction in the benefits of moderate drinking and under-treatment of drinkers with alcohol abuse or dependence who are guided toward moderate drinking rather than abstinence. The USPSTF found no data for either of these potential harms. In addition, a multi-contact intervention for preteens (fifth and sixth graders) in the primary care setting found moderate increases in drinking at 24 and 36 months post-intervention.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The U.S. Preventive Services Task Force recommendations are independent of the U.S. government. They do not represent the views of the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Health and Human Services, or the U.S. Public Health Service.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: recommendation statement. Ann Intern Med 2004 Apr 6;140(7):554-6. PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1989 (revised 2004 Apr 6)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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*Members of the Task Force at the time this recommendation was finalized.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

This updates a previously published guideline: U.S. Preventive Services Task Force. Screening for problem drinking. In: Guide to clinical preventive services, 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. p. 567-82.

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Also available from the Annals of Internal Medicine Online

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Whitlock EP, Polen MR, Green CA, Orleans CT, Klein J. Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: a summary of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med 2004 Apr 6;140(7):557-68.

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Also available from the Annals of Internal Medicine Online.

- Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use. Rockville (MD); Agency for Healthcare Research and Quality; 2004 Mar (Systematic Evidence Review No. 30).

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt JS. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site.

The following are also available:

- The guide to clinical preventive services, 2006. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2006. 228 p. Electronic copies available from the AHRQ Web site.
- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2002 May. 189 p. Electronic copies available from the AHRQ Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse. What's New from the USPSTF. Rockville (MD): Agency for Healthcare Research and Quality; 2004. Electronic copies: Available from USPSTF Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Electronic Preventive Services Selector (ePSS), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following is available:

- The pocket guide to good health for adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site

- Screening and counseling to reduce alcohol misuse: recommendations from the U.S. Preventive Services Task Force. Summary for patients. Ann Intern Med 2004 Apr 6;140(7):I-64.

  Electronic copies: Available from the Annals of Internal Medicine Online.

NGC STATUS

This NGC summary was completed by ECRI on March 26, 2004. The information was verified by the guideline developer on April 5, 2004.

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